IN THE

Supreme Court of the United States

OCTOBER TERM, 1978

No. 78-1631

LEONARD BERLIN,
Petitioner,

vs.

GILBERT NATHAN, *et al.*,
Respondents.

BRIEF OF AMICI CURIAE AMERICAN MEDICAL ASSOCIATION, AMERICAN HOSPITAL ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS, AMERICAN ASSOCIATION OF OPHTHALMOLOGY, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN COLLEGE OF RADIOLOGY, AMERICAN SOCIETY OF ANESTHESIOLOGISTS, AMERICAN SOCIETY OF INTERNAL MEDICINE, AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS, AND ILLINOIS STATE MEDICAL SOCIETY

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CONSENT OF THE PARTIES

Amici are filing this Brief in support of the Petition for a Writ of Certiorari to the Supreme Court of Illinois with the consent of all parties, whose letters of consent have been filed with the Clerk.

INTEREST OF AMICI CURIAE

The American Medical Association (A.M.A.), founded in 1847, is the nation's largest organization of licensed physicians and the principal spokesman for the medical profession in the United States. The A.M.A. is a federation of nearly 2000 state and local medical societies, with a membership of approximately 211,000 individual physicians practicing medicine throughout the United States.

The American Hospital Association, founded in 1898, is a nationwide organization with more than 6,500 member hospitals and health care institutions, as well as more than 29,000 individual members. A majority of the nation's hospitals are members of the Association.

The Illinois State Medical Society represents approximately 14,200 member physicians licensed to practice medicine in the State of Illinois. The other Amici are nationwide organizations whose members are licensed physicians practicing a particular medical specialty.

Amici have an interest in this case because the lower court's ruling effectively denies their members, and all other defendants, any recourse against persons who deliberately and maliciously bring a groundless lawsuit against them. Amici's members, as well as the patients and the health care system they strive to serve, are seriously threatened by the present epidemic of frivolous malpractice claims. Thus, Amici have a vital interest in seeing that a reasonable counterweight to these frivolous, bad-faith claims is maintained.

STATEMENT OF THE CASE

Harriet Nathan, one of Respondents herein, filed a malpractice action in the Circuit Court for Cook County, Illinois, against Petitioner, a Board-certified Radiologist,

and two other defendants. Mrs. Nathan alleged negligent diagnosis and treatment of an injury to her little finger, and she sought $125,000 in damages. In a separate action, Petitioner filed a malicious prosecution claim against Mrs. Nathan, her husband and her attorneys, alleging, in part, that the Nathan suit was groundless and willfully and wantonly brought with reckless disregard as to the truth or falsity of the allegations. *See* Petition for Writ of Certiorari ("Pet.") at 2, 7-8.

On the date set for trial, Mrs. Nathan voluntarily dismissed her malpractice suit against all defendants. Petitioner's suit, which had been consolidated with the Nathan suit, was then tried before a jury, which returned a verdict in Petitioner's favor, awarding him $2,000 actual damages and $6,000 punitive damages. In addition, the jury answered special interrogatories, finding that the Respondents had brought suit in a willful and wanton manner, without any probable cause to support their allegations. *See* Pet. at 2, 8.

On appeal, the Illinois Appellate Court reversed, holding that Petitioner's amended complaint and the instructions under which the case was submitted to the jury were insufficient to state a cause of action for malicious prosecution. The court ruled, *inter alia*, that Petitioner's complaint was deficient as a matter of law because it failed to allege some special injury, such as seizure of person or property, not necessarily occurring in other suits prosecuted maliciously and without probable cause. *See* Pet. at 2, 8-9.

The Illinois Supreme Court denied leave to appeal from that ruling, and Petitioner has petitioned this Court for a Writ of Certiorari to review the constitutional issues raised by the decision below. *See* Pet. at 2-3, 9.

SUMMARY OF ARGUMENT

The decision below reversed a trial court judgment awarding damages to Petitioner as a result of the malicious prosecution by Respondents of a malpractice claim which the trial jury found had been totally groundless and brought in a willful and wanton manner. The appellate court ruled that absent "special damages"—such as seizure of a defendant's person or property before suit—the general policy of encouraging access to the courts bars any recovery for even the most frivolous and malicious claims. Amici will show in this Brief that the ruling below ignores the very serious problems for the nation's health care system and for the courts resulting from the tremendous explosion in recent years in the number of frivolous malpractice suits filed in order to harass physicians or to extort nuisance settlements from physicians and their insurers.

The number of medical malpractice claims filed each year has increased enormously during the past decade. Between 1970 and 1975 the number of suits filed doubled to more than 20,000 per year. In Southern California by 1974 the annual number of claims per 100 physicians had increased to 26, and the figure is in all probability even higher today.

All of the major studies have found that no payment is made to the plaintiff in more than one-half of these malpractice cases, and of those claims actually determined on their merits at trial, the defendant wins 80 to 90 percent of them. However, since medical malpractice cases take longer and are more costly to defend than other personal injury cases, there is substantial pressure on the physicians and their insurers to settle these nuisance claims. Thus, payments are often made in nonmeritorious, and even frivolous, cases.

The dramatic increase in the number of actions has caused the cost of medical malpractice insurance to skyrocket. Notwithstanding increased premiums for surgeons between 1960 and 1970 of roughly 950 percent, average additional rate increases in 20 states during 1974 and 1975 alone ranged from 100 to 600 percent. Malpractice insurance for many physicians in high risk categories (*e.g.*, surgeons) now costs more than $30,000 yearly, and in some cases as much as $60,000-$70,000 per year. These escalating premiums have resulted in substantially higher health care costs to the consumer.

The increase in malpractice claims has also had a severe impact on the delivery of health care services. Because of the high cost of insurance, physicians, including many part-time and semi-retired practitioners, have quit medical practice altogether. Other physicians have migrated from geographic areas where premiums are higher, or they have left a high-risk specialty. A recent survey shows that more than one physician in five has altered his or her practice by eliminating some higher-risk procedures to cope with the rising cost of insurance. Given the existing shortages of health care services, each of these developments may seriously threaten the well-being of many patients.

Another major impact on the health care system is the widespread practice of "defensive medicine," where physicians alter their mode of practice to reduce the possibility of being sued for malpractice and to provide a proper defense in the event a lawsuit is brought. This practice adds significantly to the cost of health care and results in the misallocation of scarce medical resources.

Physicians, themselves, suffer serious injury from the filing of even frivolous claims. Since the mere filing of a claim generates adverse publicity, the physician's reputation is damaged, resulting in a direct loss of patients

and income. All physicians are harmed by the tremendous increase in the cost of insurance, and a physician who is sued for malpractice may face large surcharges even though he or she is ultimately vindicated. Moreover, the defense of even a frivolous suit requires a substantial commitment of time and energy by the physician, resulting in an additional loss of income.

Finally, the filing of frivolous malpractice claims has harmed the fair administration of justice. The Court is familiar with the serious problems of congestion and delay which now plague our state and federal courts. Because of the great number of malpractice suits and the length of time that it takes to dispose of them, these suits have contributed significantly to the serious backlogs that threaten the courts' capacity to administer justice.

In view of the very real injury that physicians suffer from the filing of frivolous malpractice claims, the courts have a duty to protect unjustly accused physicians from these claims. The ruling of the court below, however, effectively denies to physicians recourse against totally groundless claims brought for even the most malicious purposes. By requiring a showing of the type of "special damages" specified by the court below, that court has effectively eliminated the remedy altogether for unjustly accused physicians.

The policy of encouraging free access to the courts does not require preservation of the "special damages" requirement. Courts can and must distinguish between frivolous, bad-faith claims, such as the original suit against the Petitioner here, and legitimate claims brought with a proper purpose. The court below ignored this vital distinction and in so doing has contributed to the serious problems discussed in this Brief.

Legitimate claims brought in good faith, even if ultimately unsuccessful, deserve the full protection of the

courts. Suits brought to harass a doctor or to extort a nuisance settlement deserve none of those protections. Courts have a duty to identify frivolous claims and to ensure that they do not interfere with the fair resolution of legitimate controversies. Only in that way will physicians, the court system, and the public itself be properly protected.

ARGUMENT

Petitioner has sufficiently addressed in his Petition for a Writ of Certiorari the factual, procedural and jurisdictional aspects of this case. The Petition does not address fully, however, the lower court ruling's serious implications for the medical profession, the court system and the public. Amici, therefore, will confine themselves to two important points which they believe deserve the Court's concerned attention:

1. Frivolous and vexatious lawsuits, particularly against members of the medical profession, have become a serious and growing threat not only to the proper practice of medicine, and thus to the protection of the public, but also to the fair administration of justice.

2. Courts have increasingly recognized in recent times that they are not helpless in the face of nonmeritorious claims "brought to extort nuisance settlements" (*see Reiter* v. *Sonotone Corp.*, 47 U.S.L.W. 4672, 4676 (U.S., June 11, 1979)), and that plaintiffs can be penalized for asserting such claims without causing any adverse effect on the assertion of legitimate, meritorious claims. That being so, a question of constitutional dimensions is raised when a state, by whatever method, effectively cuts off a defendant's only recourse against totally nonmeritorious claims brought solely for willful and wanton purposes.

Amici will demonstrate in Section I of this Brief that there has been a tremendous increase in the number of medical malpractice actions being filed over the past

decade and that a significant portion of those claims are totally groundless and brought solely for willful and wanton purposes. In Section II of the Brief Amici will show the serious nationwide impacts that have resulted from this development, describing the impacts on the defendant physician, on patients who must pay more for health care, on the health care system generally, and on the courts.

Finally, in Section III of the Brief Amici will discuss the courts' duty to protect the unjustly accused physician and to ensure that an effective remedy is available for this serious problem. Amici will show how the ruling of the court below effectively denies a remedy altogether. In addition, Amici will explain why free access to the courts is not threatened by a remedy against frivolous and bad faith claims, since the courts can and must distinguish between such claims and legitimate controversies.

I. AN ENORMOUS NUMBER OF MEDICAL MALPRACTICE ACTIONS ARE BEING FILED IN THE COURTS EACH YEAR, AND THE EVIDENCE CLEARLY DEMONSTRATES THAT A SIGNIFICANT PORTION OF THESE CLAIMS ARE GROUNDLESS.

A. The Number of Medical Malpractice Claims Has Increased Dramatically During the Past Decade.

Medical malpractice actions such as the claim brought by Respondents in the instant case have been filed in unprecedented numbers in recent years. As early as 1969, during the first congressional study of medical malpractice, Senator Ribicoff's subcommittee found that the number of malpractice suits and claims was "rising sharply" in certain regions of the country and that the situation was "threaten[ing] to become a national

crisis." [1] By 1975 the crisis was fully upon us, as the number of medical malpractice suits being filed had doubled from the 1970 level to more than 20,000 per year and was continuing to increase steadily.[2]

Available studies confirm this dramatic increase in the number of malpractice suits filed in recent years. For example, a study of three counties in Michigan showed a 193 percent increase in medical malpractice suits filed between 1970 and 1974, with an increase of 61 percent between 1973 and 1974.[3] Likewise, in New York the number of new cases increased by 56 percent from 1969 to 1974.[4] In Cook County, Illinois, filings increased 56.7 percent between 1973 and 1974,[5] and 1,010 of the county's 7,100 physicians were sued in the 14-month period beginning January 1, 1974—an average of over 80 complaints a month.[6] It has been estimated that the fre-

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[1] Subcomm. on Executive Reorganization of the Senate Comm. on Government Operations, 91st Cong., 1st Sess., *Medical Malpractice: The Patient Versus the Physician* 1 (Comm. Print 1969) [hereinafter cited as *Ribicoff Study*].

[2] *See, e.g.*, Kisner, *Malicious Prosecution: An Effective Attack on Spurious Medical Malpractice Claims?*, 26 Case W. Res. L. Rev. 653, 654 n.3 (1976) [hereinafter cited as *Kisner*]; Boutin, *The Medical Malpractice Crisis: Is the Medical Review Committee a Viable and Legal Alternative?*, 15 Santa Clara Lawyer 405 (1975) [hereinafter cited as *Boutin*]; Shapiro, *Medical Malpractice: History, Diagnosis and Prognosis*, 1979 (No. 3) Health Care 5, 7.

[3] Physicians' Crisis Committee, *Court Docket Survey* 6-7 (1975).

[4] *See* Birnbaum, *Physicians Counterattack: Liability of Lawyers For Instituting Unjustified Medical Malpractice Actions*, 45 Fordham L. Rev. 1003, 1006 n.20 (1977) [hereinafter cited as *Birnbaum*].

[5] Steves, *A Proposal to Improve the Cost to Benefit Relationships in the Medical Professional Liability Insurance System*, 1975 Duke L.J. 1305, 1314-15 [hereinafter cited as *Steves*].

[6] Epstein, *Medical Malpractice: The Case for Contract*, 1976 Am. Bar Foundation Research Contributions 87 n.1 [hereinafter cited as *Epstein*].

quency of medical malpractice claims has been increasing at an annual rate of 12.1 percent. *See* National Center for Health Statistics, U.S. Dep't of Health, Education, and Welfare, *Medical Malpractice Closed Claim Study—1976*, at 4-1 (1978) [hereinafter cited as *HEW 1976 Closed Claim Study*].

As a result of this tremendous surge in the number of medical malpractice actions filed each year,[7] the likelihood that a physician will be sued for malpractice at least once during his or her career has become very substantial.[8] Thus, in Northern California alone, the annual number of claims *per 100 physicians* increased from 11.8 in 1968 to 21 in 1972 to 25 in 1974. In Southern California the number of such claims increased from 13.5 per 100 physicians in 1968 to 16.5 in 1973 and 26 in

[7] For additional statistical evidence concerning the frequency with which medical malpractice actions are being filed, *see Steves, supra* note 5, at 1313-15; Roddis and Stewart, *The Insurance of Medical Losses*, 1975 Duke L.J. 1281, 1296-97 ("nine out of 100 doctors had claims made against them in 1963, twenty out of 100 in 1970, perhaps thirty out of 100 today") [hereinafter cited as *Roddis*]; Birnbaum, *supra* note 4, at 1003-14 ["dramatic increase in the frequency of medical malpractice actions"]; *Epstein, supra* note 6, at 87-88 n.1; Wiske, *A Study of Medical Malpractice Insurance: Maintaining Rates and Availability*, 9 Ind. L. Rev. 594, 603 n.50 (1976) [hereinafter cited as *Wiske*]; Adler, *Malicious Prosecution Suits As Counterbalance to Medical Malpractice Suits*, 21 Cleve. St. L. Rev. 51 (1972) [hereinafter cited as *Adler*]; Rathnau, *The Illinois Medical Malpractice Acts: Response to Crisis*, 65 Ill. Bar J. 716, 718 (1977); U.S. Dep't of Health, Education, and Welfare, *Medical Malpractice Report of the Secretary's Commission on Medical Malpractice* 6 (1973) (malpractice claims "increasing steadily") [hereinafter cited as *HEW 1973 Report*; Appendix separately cited as *HEW 1973 Report (App.)*]; Gray, *The Insurer's Dilemma*, 51 Ind. L.J. 120, 121-22 (1975) (ten percent increase in medical malpractice cases each year).

[8] In fact, according to some predictions, every practicing physician can now expect to be sued at least once in his or her lifetime. Brook, Brutoco and Williams, *The Relationship Between Medical Malpractice and Quality of Care*, 1975 Duke L.J. 1197, 1206 [hereinafter cited as *Brook*].

1974.[9] In Virginia, where the claims per 100 doctors was only 2.6 in 1969, the number had risen to 7.2 per 100 doctors by 1975.[10] In certain high-risk specialties, such as surgery, anesthesiology, and obstetrics-gynecology, the chance that a physician will be sued is even greater.[11]

Given the lack of current data, it is somewhat difficult to determine whether the tremendous increases in the number of medical malpractice actions filed in the early and mid-1970's have continued during the past few years. While there are some indications that these spiraling increases may be moderating, the problem remains quite severe. In Cook County, Illinois, for example, unpublished data available to Amici show that although there was a decline in medical malpractice suits during 1976 and 1977, the number of suits increased during 1978 and the rate for the first quarter of 1979 actually exceeded the rate for the same period during the year 1975 when a record number of suits were filed. Likewise, the St. Paul Company reported that new claims per 100 physicians in 1978 increased 12 percent over 1977. *Malpractice Lifeline*, July 30, 1979, at 5. The American Medical Association has reported that while the claims

[9] Keene, *California's Medical Malpractice Crisis*, A Legislator's Guide to the Medical Malpractice Issue 27 (1976) [hereinafter cited as *Keene*].

St. Paul Fire and Marine Insurance Company, a leading medical malpractice insurer, reported a pending claim for one in every ten insured doctors in 1975, as contrasted with one claim for each 23 insured doctors in 1969. *See* St. Paul Fire and Marine Insurance Company, *An Insurance Company's View of the Malpractice Situation*, 103 Medical Times 65 (1975) [hereinafter cited as *St. Paul*].

[10] *See* Aldrich, *Alternatives to the Medical Malpractice Phenomenon: Damage Limitations, Malpractice Review Panels and Countersuits*, 34 Wash. & Lee L. Rev. 1179 n.1 (1977) [hereinafter cited as *Aldrich*], citing State Corporation Commission, *Medical Malpractice Insurance in Virginia: The Scope and Severity of the Problem and Alternative Solutions* 19 (1975).

[11] *See, e.g., Brook, supra* note 8, at 1206 n.47; *HEW 1973 Report (App.), supra* note 7, at 16-17; *St. Paul, supra* note 9, at 66.

frequency per 100 physicians declined during 1976, the frequency increased in 1977.[12] Moreover, a 1977 report found that malpractice claims had risen by nearly 50 percent since 1972.[13]

Thus, the evidence clearly shows that medical malpractice actions are being filed in numbers that were unheard of before the crisis of the mid-1970's.

B. A Significant Number of These Claims Are Entirely Baseless and Brought with an Improper Motive.

Although it is difficult to state with precision what percentage of medical malpractice claims are unjustifiably

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[12] American Medical Association, *State By State Report on Professional Liability Insurance in the United States* (Nov. 1978) [hereinafter cited as *AMA 1978 Report*].

[13] Schwartz and Komesar, *Doctors, Damages and Deterrence: An Economic View of Medical Malpractice*, 298 New Eng. J. of Med. 1282, 1286 (1978).

While a number of explanations have been offered for the dramatic increase in the number of medical malpractice actions in the past ten years, almost always included are: the increase in insurance and greater public awareness of insurance; publicity about malpractice awards; and the costs and delays of litigation forcing insurance companies to settle "nuisance" suits. *See, e.g., Birnbaum, supra* note 4, at 1007-08; *Aldrich, supra* note 10, at 1179-81; *Wiske, supra* note 7, at 595; *St. Paul, supra* note 9, at 67-76; Wessler, *The Role of Custom in Medical Malpractice Litigation*, 1975 B.U.L. Rev. 647, 660 [hereinafter cited as *Wessler*]; Wallach, *Medical Malpractice: A Professional Dilemma For the Lawyer*, J. Legal Med. 40, 41 (July/Aug. 1974); *HEW 1973 Report, supra* note 7, at 2-3, 24-5; Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma*, 1975 Duke L.J. 1179, 1181-86 [hereinafter cited as *Mechanic*]; *Roddis, supra* note 7, at 1297-1300; Annas, Katz and Trakimas, *Medical Malpractice Litigation Under National Health Insurance: Essential or Expendable*, 1975 Duke L.J. 1335, 1336-37 n.8; *Kisner, supra* note 2, at 654; Reder, *Medical Malpractice: An Economist's View*, 1976 Am. Bar Foundation Research Contributions 511, 528; Symposium, *Introduction: The Indiana Act in Context*, 51 Ind. L.J. 91, 93 (1975); *Ribicoff Study, supra* note 1, at 1, 3, 16, 447-53; Roth, *The Medical Malpractice Insurance Crisis: Its Causes, The Effects, and Proposed Solutions*, 44 Ins. Counsel J. 469, 470-73 (1977) [hereinafter cited as *Roth*].

instituted, studies show that a very large number of nonmeritorious, and even legally frivolous, malpractice claims are being brought against physicians. For example, the HEW study of claims closed during 1976 showed that only 47 percent of all claims resulted in any payment whatsoever. *HEW 1976 Closed Claim Study, supra* p. 10, at 8-5.[14] This finding is consistent with evidence from HEW's earlier study of claims closed during 1970 where only about 45 percent of all claims resulted in some payment. *HEW 1973 Report, supra* note 7, at 10.[15] More-

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[14] Other studies confirm the findings of the HEW studies. The NAIC malpractice claims study concluded that considering all dispositions the defendant prevailed 62 percent of the time. National Association of Insurance Commissioners, *Malpractice Claims*, Vol. 2, No. 1 at 129 (Dec. 1978) [hereinafter cited as *NAIC Study*]. The 1974 closed claim survey carried out by the Insurance Services Office concluded that 52-53 percent of all claims resulted in no payment to the claimant. *See* Insurance Services Office, Report of the All-Industry Committee, *Special Malpractice Review: 1974 Closed Claim Survey* 17, 41 (Nov. 1976) [hereinafter cited as *1974 Closed Claim Survey*]. The St. Paul Fire and Marine Insurance Company has reported that between 1968 and 1975 the annual percentage of claims closed without payment ranged from 51 percent to 68 percent, averaging over 60 percent nationwide. *See Report of the Interim Task Force on Medical Malpractice*, State of Oregon 126 (1976) [hereinafter cited as *Oregon Task Force*].

[15] *See generally Aldrich, supra* note 10, at 1194 ("Numerous malpractice actions are brought against physicians without justifiable cause."); *Kisner, supra* note 2, at 655 ("Available statistical information suggests that a significant percentage of the malpractice claims filed lacks either a legal or factual basis.").

It should also be noted that HEW's 1973 report includes data showing that approximately 60 percent of the total number of incidents, including pre-claims, resulted in no payment to the claimant. Rudov, Myers & Mirabella, *Medical Malpractice Insurance Claims Closed in 1970*, in *HEW 1973 Report (App.), supra* note 7, at 14 (Table 2).

In addition, the 1973 report contains evidence showing that lawyers accepted only 12 percent of the medical malpractice cases brought to them and that the most common reason for rejecting a case (41 percent of the time) was "no perceived liability." Dietz, Baird, and Berul, *The Medical Malpractice Legal System*, in *HEW*

over, the number of nonmeritorious claims is undoubtedly much larger than the number of cases in which no payment is made, because many cases are settled in order to avoid the cost of litigating the claims. *See* pp. 15-17, *infra*.

Although the studies referred to above made no attempt to determine how many of these nonmeritorious claims were entirely baseless and brought for improper reasons, they left little doubt that a significant number of malpractice claims are unjustifiably instituted against physicians.[16] Some such claims are brought solely to harass a physician as a result of the patient's ill will; others are instituted in an attempt to obtain a settlement from the physician's insurer for the "nuisance value" of a claim, since the insurer may find it economically beneficial to settle the action rather than to pay substantial defense costs; and still others are brought in response to a doctor's claim or suit for an unpaid bill. *See Birnbaum, supra* note 4, at 1017-18 and sources cited in note 16, *supra*. Claims brought for any of these reasons—like the suit of Respondents here, which the trial jury found was deliberately brought in a "willful and wanton" manner—do not deserve the protection that is

1973 Report (App.), supra note 7, at 153. Defense lawyers *and* plaintiffs' lawyers estimated that malpractice occurs in only one-third of all malpractice claims. *Id. See also* Curran, *How Lawyers Handle Medical Malpractice Cases: An Analysis of an Important Medicolegal Study* (DHEW Pub. No. HRA 76-3152, 1976) [hereinafter cited as *Curran*].

[16] *See, e.g., Aldrich, supra* note 10, at 1194; Stimson, *Physician Countersuits: Malicious Prosecution, Defamation and Abuse of Process as Remedies for Meritless Medical Malpractice Suits*, 45 Cinn. L. Rev. 604, 621-22 (1976) [hereinafter cited as *Stimson*]; *Birnbaum, supra* note 4, at 1008-09, 1017; *Adler, supra* note 7, at 53; Segar, *Is Malpractice Insurable?*, 51 Ind. L.J. 128 (1975) [hereinafter cited as *Segar*]; Blackwell and Talarzyk, *Consumer Attitudes Toward Health Care and Medical Malpractice* 17-18 (1977) (slightly more than half the claims are "nuisance" claims) [hereinafter cited as *Blackwell*].

afforded to a plaintiff who brings a legitimate claim in good faith.

Data concerning the disposition of these claims helps to explain why physicians are vulnerable to suits brought to extort a settlement. Medical malpractice claims take longer to prepare and try than other personal injury cases and, thus, are more costly to defend. *See HEW 1973 Report, supra* note 7, at 42; *Curran, supra* note 15, at 3. HEW's Malpractice Commission found that medical malpractice cases take two to three times longer to try than other personal injury cases because of the complexity of expert medical testimony. *HEW 1973 Report, supra* note 7, at 18. Lawyers surveyed in the HEW study estimated that the typical medical malpractice case requires three-and-a-half to four times the number of attorney hours as do other personal injury cases. *See Curran, supra* note 15, at 18.

The HEW study of claims closed in 1970 found that only half of all malpractice claims are closed within 18 months after the file is opened, and ten percent remained open 6½ years after the file is opened. *HEW 1973 Report, supra* note 7, at 11. The 1974 closed claim survey found the average time between the incident date and settlement to be 31 months. *1974 Closed Claim Survey, supra* note 14, at 13. The NAIC study found the average time from incident to disposition to be 37 months. *NAIC Study, supra* note 14, at 17.[17]

Thus, medical malpractice actions are more costly to prosecute and defend than other personal injury cases. *See, e.g., HEW 1973 Report, supra* note 7, at 35, 89. Data recently complied by A. M. Best Company show that in medical malpractice actions loss adjustment ex-

[17] *See also HEW 1976 Closed Claim Study, supra* p. 10, at 3-4 (reporting a mean processing time of 19.4 months from filing of the claim to final disposition); *Ribicoff Study, supra* note 1, at 8-9.

penses (legal defense, investigation and unallocated expenses) are much higher in comparison to total indemnity payments than is the case in other liability actions. The ratio of loss adjustment expenses to indemnity losses averages .446 for the medical malpractice line, as compared to .174 for private passenger automobile liability, and .373 for other liability lines.[18] In a report complied by actuarial consultants to the Illinois State Medical Inter-Insurance Exchange for an official filing with the Illinois Department of Insurance for the 1979-80 policy year, it was recently estimated that the average claims expense (legal defense costs) is now $6,086 per claim. Milliman & Robertson, Inc., *Report to the Illinois State Medical Inter-Insurance Exchange* Exh. 31 (April 4, 1979). These higher costs are largely due to the need for expensive diagnostic procedures and, as noted above, expert medical testimony. *See Wiske*, *supra* note 7, at 604 n.58; Mallor, *A Cure for the Plaintiff's Ills?*, 51 Ind. L.J. 91, 105 (1975). The Ribicoff subcommittee reported that as much as 55 percent of the money paid by insurance companies for malpractice claims may go to defense attorney and investigation costs. *Ribicoff Study*, *supra* note 1, at 10.[19]

Few malpractice claims proceed to trial, and of those that do, the plaintiff seldom wins. HEW's Malpractice Commission found that fewer than ten percent of all claims are tried. *HEW 1973 Report (App.)*, *supra* note 7, at 13.[20] The 1974 closed claim survey concluded that only seven percent of the claims go to verdict and that

[18] A. M. Best Co., *Best's Aggregates & Averages: Property-Casualty*, 128, 135, 139, 43B, 47B, 49B, 63B, 64B (1978). These ratios were computed by averaging the figures given for each liability line for stock, mutual and reciprocal companies.

[19] Defense costs for cases in which no payment was made represent about 35 percent of total defense costs expended in all cases. *1974 Closed Claim Survey*, *supra* note 14, at 12.

[20] *Accord, Adler*, *supra* note 7, at 52.

the defendant prevails 78 percent of the time. *1974 Closed Claim Survey*, *supra* note 14, at 13. Similarly, the NAIC determined that of all claims resolved by trial, the plaintiff prevailed only nine percent of the time. *NAIC Study*, *supra* note 14, at 4, 129-30.

This evidence shows that when the merits of medical malpractice claims are actually reached and determined, a very small percentage are found to have substance. Nevertheless, because of the time and expense of defending a typical malpractice claim, physicians and their insurers are forced to settle a larger number of nuisance suits and other groundless claims brought to harass or for other improper motives.[21]

II. THE FILING OF FRIVOLOUS MALPRACTICE CLAIMS HAS HAD A DEVASTATING IMPACT ON THE NATION'S HEALTH CARE SYSTEM AND JUDICIAL SYSTEM.

A. There Has Been an Enormous Increase in Medical Malpractice Insurance Premiums Which, in Turn, Has Resulted in Higher Health Care Costs to Patients.

The dramatic increase in the number of medical malpractice actions has caused the cost of medical malpractice insurance to "skyrocket." *Birnbaum*, *supra* note 4, at 1003-04. These tremendous malpractice insurance costs have contributed substantially to the recent rises in patients' health care costs.

The recent increases in medical malpractice insurance premiums are staggering. According to the HEW's 1973 report, premiums for physicians other than surgeons rose 540.8 percent between 1960 and 1970, and for surgeons

[21] *See generally Curran*, *supra* note 15, at 19; *Roth*, *supra* note 13, at 473; *Birnbaum*, *supra* note 4, at 1008-09.

they rose 949.2 percent. *HEW 1973 Report, supra* note 7, at 13.[22]

Notwithstanding these huge increases during the 1960's premiums have increased even more during the present decade. A nationwide survey conducted in early 1975 showed average rate increases in 20 states during 1974 and 1975 ranging from 100 to 600 percent. *American Medical News*, Feb. 24, 1975, at 1. In Ohio, for example, rates for the lowest risk physicians rose 423 percent in October 1974, and for the highest risk category they rose 747 percent. *Id.* at 13. In January 1975 rates in Michigan rose as much as 658 percent. *Id.* at 10.[23] In Illinois, premiums for physicians in the high risk category increased tenfold between 1968 and 1976. *Blackwell, supra* note 17, at 20. Argonaut Insurance increased its premiums 380 percent for 4,000 doctors in Northern California in 1975.[24] *Keene, supra* note 9, at 27. The St. Paul Company reported that its insured doctors would face premium increases in 20 of 29 states in 1979. *Malpractice Lifeline*, July 30, 1979, at 5.

Comprehensive figures concerning the amounts doctors actually pay for malpractice coverage are not readily available. However, some examples from available figures

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[22] In Utah, for example, the rates for the year 1969 were thirteen times what they had been in 1967. *Adler, supra* note 7, at 52.

[23] For a state-by-state breakdown of rates and increases *see American Medical News*, Feb. 24, 1975, at 1.

[24] As explained by one HEW report:

> All across the country in state after state in early 1975 the shock waves hit. The insurance carriers announced either that they were dropping malpractice insurance completely by July 1, or they announced rate increases of from 200 to 600 percent for physicians and even larger increases for hospitals. Some hospitals asked to pay huge increased premiums had never lost a single malpractice case. These increases often followed upon other very sizeable increases granted in the early seventies. [*Curran, supra* note 15, at 34.]

are startling. For example, in New York the proposed 1975 premium for neurosurgeons and orthopedists was $43,000, in contrast with the 1965 premium of $819 and the 1974 premium of $14,000 paid by the same physicians. *Boutin, supra* note 2, at 407. In Southern California, by 1976, according to ISO ratings, coverage with $100,000/$300,000 policy limits was costing certain surgeons $37,066. *Brook, supra* note 8, at 1211 n. 58.[25] Other evidence suggests that some specialists may be paying premiums of more than $60,000 per year for basic coverage,[26] and one calculation for "high-risk" surgeons in California shows a premium of $77,674 a year.[27] According to the 1975 American Medical News survey, those physicians who could not obtain coverage through the Illinois State Medical Society group policy then went to Lloyds of London, which was charging $48,000 a year for claims-made coverage for high-risk physicians. *American Medical News*, Feb. 24, 1975, at 10.[28] As a result of figures like these, there has been serious concern in recent years about the availability of medical malpractice insurance even at exorbitant rates.[29]

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[25] *See also* Redish, *Legislative Response to the Medical Malpractice Criiss: Constitutional Implications* 1-2 (1977).

[26] *See, e.g.*, Hale and Podell, *Medical Malpractice in New York*, 27 Syracuse L. Rev. 657, 783 (1976) [hereinafter cited as *Hale*]; D. Louisall & H. Williams, *Medical Malpractice* 5 (1978 Supp.).

[27] *Steves, supra* note 5, at 1320.

[28] Notwithstanding these tremendously high base figures, physicians who had been sued for malpractice one or more times might also face surcharges ranging from 30 to 50 percent, *without regard to the outcome of the suit.* *See* p. 28, *infra*.

[29] During the mid-70's many insurers withdrew from the medical malpractice field altogether. *See, e.g., Birnbaum, supra* note 4, at 1016; *Wiske, supra* note 7, at 594; *Aldrich, supra* note 10, at 1180 n.4; *Boutin, supra* note 2, at 424-25; *Blackwell, supra* note 16, at 20; *Hale, supra* note 26, at 783; *HEW 1973 Report (App.), supra* note 7, at 495; *Segar, supra* note 16; *Keene, supra* note 9, at 27. Physicians in some states and some specialties were un-

Even where insurance is available, the rapidly escalating premiums[30] have resulted in substantially higher health care costs to the consumer, since it is well established that these premium increases generally are passed on to the patient through higher fees.[31] HEW's Malpractice Commission estimated that a hospitalized patient pays approximately 50 cents each day for the hospital's professional liability insurance, and that patients pay 20 to 50 cents out of every $10.00 fee for their doctor's insurance. *HEW 1973 Report, supra* note 7, at 13. By 1975 the AMA estimated that each visit to a doctor cost the

able to obtain any coverage or had to accept lower policy limits than were sought. *Id.* It has been reported that the number of insurance carriers writing medical malpractice insurance decreased from approximately 85 to five. Redish, *Legislative Response to Malpractice Insurance Crisis: Constitutional Implications*, 55 Texas L. Rev. 759, 760 n.4 (1977) [hereinafter cited as *Redish*]. Although the availability situation may not be as critical at present, some states foresee continuing insurance availability problems. *See Impact*, April 28, 1978, at 7. In fact, one report estimates that 10 percent of California's physicians are "going bare," that is, without any malpractice insurance. *AMA 1978 Report, supra* note 12, at 5. As one state task force studying the medical malpractice problem concluded, "[M]aintaining the availability of an adequate form of insurance protection for physicians in this state is essential to the welfare of [its] citizens * * *." *Oregon Task Force, supra* note 14, at 13.

[30] Even with the advent of physician-owned/medical society created liability insurance companies, premiums are still extremely high. In a report of data collected through the American Medical Assurance Company of 21 such companies in May 1979, annual premiums range as high as $31,360 (NORCAL Mutual), $30,144 (MIEC), $23,856 (SCPIE), $22,292 (New York), $21,400 (Illinois), $18,000 (Michigan), $17,500 (Florida), and $17,400 (New Jersey). *See* American Medical Assurance Company, *Uniform Data Report* (May 1979). In addition, the physicians are required to make a substantial contribution to capital.

[31] *See, e.g., Birnbaum, supra* note 4, at 1016 n.91; *Wiske, supra* note 7, at 595; *Boutin, supra* note 2, at 423; *Wessler, supra* note 13, at 661; *HEW 1973 Report, supra* note 7, at 12 and (*App.*) 552; *Ribicoff Study, supra* note 1, at 2; *Roth, supra* note 13, at 474; *HEW 1976 Closed Claim Study, supra* p. 10, at 1-1, 6-2.

average patient $1.24 for his or her physician's malpractice insurance. *Blackwell, supra* note 16, at 18.[32] In fact, an AMA study indicated that over a two-year period doctors raised their fees 96 cents per visit because of malpractice insurance costs. *Birnbaum, supra* note 4, at 1016 n. 91. When one insurance company announced its proposed increases in December 1974, it was estimated that the increases would have added an additional $50.00 to each patient's bill for an average hospital stay of seven to ten days.[33]

Thus, the huge increase in medical malpractice claims has caused a corresponding jump in malpractice insurance costs, a factor which has contributed substantially to the nation's extremely high health care costs.

B. Nonmeritorious Malpractice Claims Have Other Negative Effects on Our Health Care System.

The enormous increase in medical malpractice claims, a significant portion of which are groundless, and the attendant surge in malpractice premiums, have had a severe impact on our health care system, in addition to the increase in costs to patients discussed above.

First, there is evidence that some physicians have left medical practice altogether because of rising insurance costs. The Ribicoff subcommittee cited reports in its 1969 study that 350 physicians in California had quit medical practice because of the cost of malpractice insurance. *Ribicoff Study, supra* note 1, at 10. In a recent survey of Oregon physicians, 8.8 percent of those re-

[32] *See also Brook, supra* note 8, at 1213 (a physician whose premium increases $5,000 for a given year may increase the fee for each office visit by $1.00); *Boutin, supra* note 2, at 423-24 (as much as five percent of total fee goes to pay doctor's malpractice insurance premiums).

[33] *See* Lombardi, *New York's Medical Malpractice Crisis*, A Legislator's Guide to the Medical Malpractice Issue 44 (1976).

sponding indicated that they had "retired or made definite plans to retire from active practice earlier than [they] had formerly planned" as a result of increased malpractice insurance rates. *Oregon Task Force, supra* note 14, at 198. Similar results have appeared in other recent surveys. *See Impact*, April 28, 1978, at 13; *American Medical News*, Feb. 24, 1975, at 10, 15.

Second, a more widespread consequence of escalating insurance costs is that part-time and semi-retired practitioners frequently are forced to give up their practices, adding to the problem of limited availability of health care services. *See, e.g., Ribicoff Study, supra* note 1, at 10; *Blackwell, supra* note 16, at 19; *Brook, supra* note 8, at 1212; R. Gots, *The Truth About Medical Malpractice* 175 (1975). The 1975 American Medical News survey showed that at least five physicians in Michigan had retired early due to rising insurance costs. *American Medical News*, Feb. 24, 1975, at 11. This development is hardly surprising, since at today's rates premiums alone can exceed a part-time physician's income.

Third, in some instances the high cost of insurance has brought about a physical migration of physicians from geographic areas where premiums are higher. *See, e.g., Redish, supra* note 29, at 760. This was observed in Michigan during the American Medical News survey, where at least eight physicians had left the state for a lower cost area, and in Indiana. *American Medical News*, Feb. 24, 1975, at 10, 11. Obviously, patients in the abandoned areas may be seriously prejudiced by such migration if it occurs in significant numbers. *Redish, supra* note 29, at 760.

A fourth consequence of high insurance costs is that many physicians have left high-risk specialties or have limited their practice by eliminating some services that might place them in a higher-risk insurance category. *See, e.g., Blackwell, supra* note 16, at 18; Symposium,

Introduction: The Indiana Act in Context, 51 Ind. L.J. 91, 93 (1975); *Redish, supra* note 29, at 760. In fact, during the 1978 survey of 1,000 physicians, 21.5 percent responded that in order to cope with rising insurance premiums, they had "limited their practice, and no longer performed procedures that put them into higher risk more costly insurance categories." *Impact*, April 28, 1978, at 13.[34] Thus, more than one physician in five actually altered his or her practice due to rising premiums. To the extent that any shortage of services exists in a given specialty, patients in general are seriously jeopardized. Moreover, given the existing shortage of health care services generally, this development represents a very serious problem.[35]

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[34] *Accord, Oregon Task Force, supra* note 14, at 198, where 17.5 percent of the responding physicians indicated that they had "modified the nature of [their] practice in order to fall within a lower premium rating class."

[35] In the Preamble to the Medical Malpractice Reform Act of 1975 the Florida legislature found as follows:

> WHEREAS, the cost of purchasing medical professional liability insurance for doctors and other health care providers has skyrocketed in the past few months; and
>
> WHEREAS, it is not uncommon to find physicians in high-risk categories paying premiums in excess of $20,000 annually; and
>
> WHEREAS, the consumer ultimately must bear the financial burdens created by the high cost of insurance; and
>
> WHEREAS, without some legislative relief, doctors will be forced to curtail their practices, retire, or practice defensive medicine at increased cost to the citizens of Florida; and
>
> WHEREAS, the problem has reached crisis proportion in Florida * * *. [Preamble to 1975 Fla. Laws ch. 75-9.]

See also Woods v. Holy Cross Hospital, 591 F.2d 1164, 1174 (5th Cir. 1979) where the court said, "This crisis would cause injury not only to the health care industry but also to the citizenry of Florida; as physicians curtailed their practices, retired, or practiced defensive medicine and other health care providers restricted

These same considerations obviously affect young physicians who are starting into practice, perhaps even more than established physicians. The high cost of malpractice insurance will affect their decisions concerning specialization and geographic location. *See, e.g., Ribicoff Study, supra* note 1, at 9; *Blackwell, supra* note 16, at 18, 19; Symposium, *Introduction: The Indiana Act in Context*, 51 Ind. L.J. 91, 92 (1975).[36]

Finally, another result of the tremendous increase in medical malpractice suits has been the practice by physicians of "defensive medicine," [37] which adds to the overall cost of health care and results in the misallocation

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their services both the quantity and quality of health care in Florida would diminish."

In December 1974 a hospital in Indiana announced that it was discontinuing all elective surgery because its anesthesiologists were unable to renew their insurance policies. Only through intervention of the state insurance commisisoner were the anesthesiologists able to obtain coverage for a trial period pending developments in the state legislature, at rate increases of 500 to 600 percent. Stewart, *The Malpractice Problem—Its Cause and Cure: The Physician's Perspective*, 51 Ind. L.J. 134, 137 (1975) [hereinafter cited as *Stewart*].

See also Renslow v. Mennonite Hospital, 67 Ill. 2d 348, 367 N.E.2d 1250, 1265 (1977) (Ryan, J., dissenting): "In some states the so-called malpractice crisis has resulted in the closing of hospital emergency services, the withdrawal of insurance writers from the field, and the abandonment by some physicians of their chosen specialties."

[36] For example, in San Francisco a group of pediatricians hired a young anesthesiologist who was just entering practice at a salary of $42,000 a year. When he attempted to obtain liability insurance, most companies were not interested, but one was willing to write a policy for $32,000 a year, 75 percent of his income before taxes. *Stewart, supra* note 35, at 137.

[37] HEW's Commission defined defensive medicine as "the alteration of modes of medical practice, induced by the threat of liability, for the principal purposes of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted." *HEW 1973 Report, supra* note 7, at 14.

of health care resources.[38] Defensive medicine may occur in several forms. A physician may perform a procedure "which is not medically justified but is carried out primarily (if not solely) to prevent or defend against the threat of medical-legal liability." *Id.* A doctor may decide not to perform a given procedure because of fear of a later malpractice suit, even though the procedure may be justified. *Id.* HEW's Commission also noted a third form of defensive medicine, namely, a reluctance on the part of physicians to publish case reports in medical journals describing adverse effects of diagnostic and therapeutic procedures. *Id.* Obviously, each of these forms of defensive medicine has a very serious negative impact on the provision of proper health care services.

Available evidence indicates that the practice of defensive medicine, due to the threat of malpractice liability, is widespread. In the Ribicoff study it was noted that "the specter of malpractice litigation" has caused physicians to be "overly cautious" in many areas. *Ribicoff Study, supra* note 1, at 22.

> For example, it has become commonplace for physicians to order complete x-ray studies of an injured limb even without the slightest indication of a fracture. Needless to say, these x-rays can add $20 to $30 to the patient's bill even though they may be unwarranted in 99 out of 100 cases. [*Id.*]

HEW's Commission in 1973 noted that nearly every physician who had testified before it cited the practice of defensive medicine as a harmful result of the increasing number of malpractice suits. *HEW 1973 Report, supra* note 7, at 14. The Commission also cited surveys of physicians which found that 50 to 70 percent of those surveyed practiced defensive medicine because of the

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[38] HEW's Commisison has termed defensive medicine "one of the most pervasive impacts of the medical malpractice problem * * *." *HEW 1973 Report, supra* note 7, at 14.

threat of being sued. *Id.*, Bernzweig, *Defensive Medicine*, in *HEW 1973 Report (App.)*, *supra* note 7, at 38, 39. In a recent survey of Oregon physicians, 88.1 percent indicated that they do practice defensive medicine, including 73.8 percent who use more X-rays and 70.5 percent who use more laboratory tests. *Oregon Task Force*, *supra* note 14, at 201.[39]

Not only does defensive medicine inflate the cost of health care, but it has resulted in misallocation of scarce medical resources. *See, e.g., HEW 1973 Report (App.)*, *supra* note 7, at 40; *Roth*, *supra* note 13, at 474. *See generally*, Project, *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 Duke L.J. 939, 943:

> Utilizing the physician's time and hospital facilities for defensive medicine reduces the quantity of care available for legitimate health needs, and, at a time when the demand and need for health care exceeds its supply, any such misallocation of resources is of crucial significance.[40]

[39] Another recent survey also found that more than 80 percent of the participating physicians had changed their method of practice because of concern over legal liability. The same survey indicated that 48 percent were ordering extra diagnostic tests because of fear of malpractice litigation. *See Wessler, supra* note 13, at 659.

A comprehensive survey of the practices of Texas physicians resulted in findings that because of the wave of malpractice claims: (1) 67 percent were ordering more x-rays; (2) 66 percent were ordering more lab tests; (3) 51 percent made greater use of a second physician's opinion; (4) 50 percent were delegating less responsibility for the patient's care; and (5) 48 percent were hospitalizing their patient more often. *See Blackwell, supra* note 16, at 18.

Since 1969 the number of all in-patient laboratory tests has been increasing at a rate of 7-18 percent annually per patient, and x-ray tests alone have been increasing at the rate of four to twelve percent per patient annually. *See Roth, supra* note 13, at 474. This in all probability is additional evidence of the practice of defensive medicine.

C. The Filing of Even a Frivolous Malpractice Claim Causes Irreparable Harm to the Defendant Physician.

Not surprisingly, the most obvious and immediate negative effects from the recent increases in malpractice claims fall upon defendant physicians themselves, like Petitioner in the instant case. What is especially troubling and surprising about this otherwise expected result is that these physicians are likely to suffer most of the same harms whether or not they are ultimately vindicated. In fact, even the most frivolous claim, brought simply to harass the physician, is likely to cause most of the same negative consequences that occur in the case of a meritorious claim.

The mere filing of a malpractice claim generates adverse publicity, causing harm to the physician's reputation, which results directly in a loss of patients and income. *See, e.g., Birnbaum, supra* note 4, at 1015. The physician's reputation is of paramount importance for most people in choosing a doctor. *See generally Blackwell, supra* note 17, at 30 (Table 3-4). In fact, a comprehensive study of consumer attitudes on health care showed that 49 percent of the people surveyed considered it important to know whether a doctor had ever been sued for malpractice (without regard to outcome), including 33.5 percent who felt it was "very important." On the other hand, only 24.5 percent felt that whether the physician had been sued was unimportant. *Id.* at 31 (Table 3-5). If one half of the population considers the

[40] Although it is sometimes asserted that physicians practice "better" medicine because of the fear of malpractice suits, Eli Bernzweig, who was the Executive Director of the HEW Commission on Malpractice, has concluded that "there undoubtedly are more who practice worse medicine because of this fear." *Segar, supra* note 16, at 129 (citation omitted).

mere filing of a claim against the doctor to be an important consideration in choosing a doctor, obviously such claims, whether totally unfounded or not, will have a direct impact on the doctor's number of patients and income.

Another economic consequence which flows directly from the mere filing of a claim against the physician and from the filing of a large number of frivolous claims is the enormous increase in the cost of medical malpractice insurance, as discussed above. In many cases physicians' premiums will increase as a result of the mere filing of suits against them, without regard to outcome.[41] For example, a 1975 survey of insurance rates revealed that one company, which was the largest insurer in several states, was adding surcharges in several states of thirty percent for any doctor who had been sued once in the past three years and fifty percent if he or she had been sued twice, without regard to the outcome of the suit. *American Medical News*, February 24, 1975, at 10. Moreover, these surcharges would automatically continue in effect for three policy years, even if the suit were resolved in the physician's favor during that time. With base premiums alone often amounting to tens of thousands of dollars, *see* pp. 18-20, *supra*, surcharges of thirty to fifty percent are a serious problem for any physician.[42]

[41] *See, e.g., Birnbaum, supra* note 4, at 1015 ("Even if the physician is ultimately successful in defending the malpractice action, he may still sustain a substantial economic loss, since his insurance premiums may be increased or his insurance may be cancelled altogether"). *See also Curran, supra* note 15, at 34 (during 1975 hospitals which had never lost a single malpractice claim were required to pay huge increases in their insurance rates).

[42] While the medical profession's regular insurance premium costs generally are passed on to patients in the form of higher fees, *see* pp. 20-21, *supra*, individual doctors faced with stiff surcharges on their premiums due to malpractice claims may be prevented by competitive factors from recovering such extraordinary costs which other local doctors may not face.

Another example of the consequences which result without regard to the outcome of the suit is the reporting requirements which have been enacted in several states. *See Birnbaum, supra* note 4, at 1014 n.75. For example, in New York every medical malpractice insurer must file a report with the state of all claims for medical malpractice made against any of its insureds. N.Y. Ins. Law § 335 (McKinney 1978). Illinois law, *see* Ch. 73 Ill. Rev. Stats. § 767.19, requires that all suits alleging liability on the part of any physician for medically related injuries shall be reported to the Director of Insurance. The Director is required to maintain complete records of all claims and report that information to the appropriate disciplinary and licensing agencies.[43]

Another direct economic consequence of the filing of even a totally frivolous suit against a physician is the substantial commitment of time and energy required to prepare and present a defense. A physician must take this factor into account in determining whether to agree to the settlement of a nuisance claim.[44] Attendance throughout several days or weeks of trial can result in a substantial loss of income to the physician.

The economic consequences of being sued, although severe, are often not the most serious consequences which the defendant physician faces. *See, e.g., Birnbaum, supra* note 4, at 1015. The mental anguish and uncertainty which many physicians experience may be the most difficult aspect to deal with. Moreover, the disruptive effect while the claim lingers in the courts may prevent the

[43] When a physician reports a claim to the Illinois State Medical Inter-Insurance Exchange, the claim is reviewed by a physician review panel and "points" are assessed against the insured physician. According to data compiled by Amicus Illinois State Medical Society, for the policy year July 1, 1978 to June 30, 1979 a total of 269 claims were reviewed by the panel of experts, and approximately 80 percent of them were found to be nonmeritorious.

[44] *See, e.g., Med. Econ.*, Aug. 21, 1978, at 154.

physician from resuming a normal practice. *See Mechanic, supra* note 13, at 1180:

> Perhaps the most troublesome aspect of having a malpractice claim made against a physician is the anxiety, lost time, and uncertainty that may be involved. Even when such claims are rejected, and physicians vindicated, being sued is an unpleasant and disruptive experience. Thus, the cost to the physician must be weighed not only in terms of the awards actually made, but in terms of the total costs of becoming entangled in such an incident. A claim made against a conscientious physician may cause him considerable suffering and may distract him from his best efforts.

This mental anguish and disruption provide a strong incentive for the physician to want to resolve the entire matter as quickly as possible, even at the cost of compromising a frivolous claim.

Finally, all of the negative effects of the volume of nonmeritorious malpractice claims on the health care system discussed above also have a direct and immediate impact on the defendant physician. Obviously, the physician who is forced to quit medical practice altogether, or to give up a part-time practice, has suffered an irreparable harm. Likewise, a physician who is forced to leave a chosen geographic area or medical specialty has also suffered extreme harm. The same can be said of each of the one in five physicians who has had to limit his or her practice due to the medical malpractice problem. Thus, the physician who is sued for medical malpractice, albeit without any merit and for improper reasons, suffers severe and irreparable injury.

D. The Filing of Frivolous Malpractice Claims Has Hindered the Fair Administration of Justice.

In addition to the medical-related impacts described above, the filing of large numbers of frivolous medical malpractice claims has contributed significantly to the

very serious problem of congestion in the state and federal courts which, in turn, severely impacts on the administration of justice.

In 1973, even before malpractice suits were being filed at their present rate, HEW's Malpractice Commission found:

> Medical malpractice cases are among the most difficult to try. They usually take two to three times longer than other personal injury cases because of the complexity of the requisite expert medical testimony. Thus, although few in total number, they contribute significantly to the congestion and overload of the court system. [*HEW 1973 Report, supra* note 7, at 18.]

With medical malpractice suits now being filed at a rate of approximately 20,000 new cases each year, it is logical to conclude that medical malpractice suits are now contributing an even greater proportion to the problem of congestion in the courts.[45]

Among the principal causes for public dissatisfaction with the courts is that the public perceives the courts as being too crowded, too slow and too expensive.[46] A recent national survey of attitudes toward state and local courts revealed that 62 percent of the people who had had any

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[45] *See Birnbaum, supra* note 4, at 1016 ("Increased numbers of malpractice claims add to court congestion and adversely affect already overburdened court personnel and facilities. Wrongfully instituted malpractice actions which would be vigorously defended, of course, exacerbate this condition").

[46] In 1906 when Roscoe Pound spoke of the causes of dissatisfaction with the administration of justice, the "uncertainty, delay and expense" of litigation were cited as major causes creating "a deep-seated desire to keep out of court, right or wrong, on the part of every sensible business man in the community." R. Pound, *The Causes of Popular Dissatisfaction with the Administration of Justice, reprinted in* 35 F.R.D. 273, 284 (1964). Those concerns are certainly no less pressing today and have even more impact on physicians than on businessmen.

experience with a state court viewed efficiency in the courts as a "serious" or "very serious" problem. National Center for State Courts, *The Public Image of Courts* 19 (Table II.1) (1978). When those who saw the problem as being "moderately serious" are added, the total increases to 88 percent. *Id.* Only 3 percent of the people surveyed viewed efficiency in the courts as not being a problem. *Id.*

The caseload statistics for the federal courts demonstrate that their dockets too are becoming increasingly overburdened. For example, the most recent report of the Director of the Administrative Office of the United States Courts shows that civil filings in federal district courts have increased 59 percent since 1970. Administrative Office of the United States Courts, *Annual Report of the Director* 104 (1978). The year-end caseload of the Courts of Appeals was 89 percent higher than the comparable figure for 1970. *Id.* at 102.[47]

The delay in the courts means more than that many cases are taking longer to be heard. Delays directly affect the just resolution of disputes. As one federal judge recently explained:

> Achievement of justice, of course, is rendered absolutely impossible by delay. Witnesses will move away, documents will be lost, memories will fade, and the adage that justice delayed is justice denied is absolutely true. Justice is impossible if you do not reach these cases promptly and try them expeditiously. [King, *Management of Civil Case Flow from Filing to Disposition*, 75 F.R.D. 155 (1978).]

Speaking at the second Pound Conference in 1976, Mr. Chief Justice Burger noted, "Inefficient courts cause de-

[47] It is interesting to note that from 1940 to 1970, the number of personal injury cases multiplied five times, and in 1977 alone, the number increased 7.3 percent over 1976. Wallace, *Our Judicial System Needs Help: A Few Inside Thoughts*, 12 U.S.F.L. Rev. 3, 9 n.31 (1977).

lay and expense, and diminish the value of the judgment. * * * Inefficiency drains the value of even a just result either by delay or excessive cost, or both." Burger, *Agenda for 2000 A.D.—A Need for Systematic Anticipation*, 70 F.R.D. 83, 92 (1976).[48]

Thus, frivolous malpractice claims not only waste the time of overburdened courts, but they prevent the courts from justly resolving legitimate claims.

III. ALTHOUGH PHYSICIAN COUNTERSUITS FOR MALICIOUS PROSECUTION CAN SERVE THE IMPORTANT PURPOSES OF DETERRING FRIVOLOUS MALPRACTICE CLAIMS AND COMPENSATING INJURED PHYSICIANS, THE LOWER COURT'S RULING EFFECTIVELY ELIMINATES ANY SUCH CAUSE OF ACTION.

A. The Lower Court's Ruling Effectively Cuts Off the Physician's Only Recourse Against Frivolous and Bad Faith Claims.

In view of the serious injury that physicians suffer from the filing of even frivolous malpractice claims against them, the courts have a duty to protect unjustly accused physicians from groundless and bad-faith claims. The lower court's ruling in the instant case, however, effectively denies recourse to any physician against totally frivolous claims brought solely for willful and wanton purposes. The jury specifically found that the original suit was filed willfully and wantonly without any prob-

[48] The problem of suits brought for unjustifiable reasons, even by the United States Government, has reached a point where Congress itself may intercede. On July 31, 1979 the Senate passed a bill (S.265) which provides for the award of attorneys' fees and other costs to a prevailing party (limited to individuals with net assets of less than $1 million and corporations with net assets of less than $5 million) in civil actions brought by or against the United States, unless the court finds that the position of the United States was "substantially justified."

able cause. Nevertheless, under the Illinois appellate court's ruling requiring "special damages," it is simply inconceivable that Petitioner and others like him could ever prevail on a cause of action for malicious prosecution.

In its opinion the appellate court listed as one element of a cause of action for malicious prosecution "special damages," meaning, under Illinois law, damages "not necessarily resulting in any and all suits prosecuted to recover for like causes of action." Pet. at 6a. For Petitioner, this meant, according to the court, that he would have to show "damages suffered specially by [him] as distinct from other physicians who have been defendants in malpractice suits." *Id.* Thus, no matter how real and substantial the injury suffered by the unjustly accused physician may be, unless the nature of the damage suffered is peculiar to him alone, as distinct from the types of damage suffered by most other defendant physicians, he has no remedy against the bad-faith litigant. Applying this rule, the court refused to consider as special damages Petitioner's claims that (1) his professional reputation had been injured; (2) he had suffered mental anguish; and (3) he had been forced to spend time and resources on the defense of a frivolous case. The court called these items "so patently common to all litigation that no discussion is warranted." *Id.* In addition, with respect to Petitioner's claim that he would be unjustly required to pay increased insurance premiums due to Respondents' groundless action, the court viewed that claim as "an item necessarily incident to all malpractice cases and not therefore amounting to damages suffered specially" by Petitioner as distinct from other defendant physicians who are subject to frivolous malpractice claims. *Id.*

It may well be true that all of the harms described herein are suffered by nearly every physician who is the victim of a frivolous and bad faith malpractice lawsuit.

That fact does not make a remedy any less necessary or the absence of one any more supportable; indeed, it simply demonstrates the broad need for such relief. It is difficult to conceive of circumstances in today's society under which a physician would suffer special damages of the kind the Illinois courts have required—namely, arrest of the physician or seizure of the physician's property. *See Birnbaum, supra* note 4, at 1022-23 n.120. It is this fact which has led the commentators to agree that in the minority of jurisdictions, like Illinois,[49] which require strict proof of "special damages," "the physician's ability to assert a cause of action for malicious prosecution is illusory;"[50] "a suit for malicious prosecution against a defendant who had brought an unfounded suit for medical malpractice would be barred;"[51] and these "jurisdictions have continued to withhold the remedy" through the arbitrary special damages requirement.[52] It is uniformly recognized that physicians who are unjustly sued in those jurisdictions are totally without any remedy, no matter how frivolous the claims against them and no matter how serious the injuries suffered by them.[53]

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[49] The Restatement of Torts adopts the majority rule and evidences recognition of the harms which physicians suffer by allowing for recovery of, *inter alia*, harm to reputation, expense of defending the original suit, any pecuniary loss arising out of the suit, and emotional distress. *Restatement (Second) of Torts* § 681 (1977).

[50] *Birnbaum, supra* note 4, at 1022-23 n.120.

[51] *Adler, supra* note 7, at 55.

[52] *Kisner, supra* note 2, at 678.

[53] Not only physicians, but all persons against whom frivolous and malicious suits are brought, are left without any remedy in jurisdictions which impose the arbitrary special damages requirement. For example, evidence presented by Petitioner based on a study of reported decisions shows that since 1848, in Illinois, plaintiffs in malicious prosecution actions have prevailed only eight times where the underlying suit was a civil action. *See* Pet. at 24-25.

We submit that the courts in jurisdictions which purport to require "special damages," but which in fact have eliminated all recovery, have totally neglected their duty to protect the unjustly accused physician. Deterrence of spurious suits is only one of the values served by malicious prosecution actions. *See Kisner, supra* note 2, at 661-662 (footnote omitted):

> The assertion that the value of malicious prosecution actions lies only in their possible deterrent effects on the institution of spurious suits disregards the need to protect and compensate those maligned by a misuse of the legal process. The value that has been placed on the right to bring a cause of action must be considered in light of both the interest of the "peaceful citizen" to be free from vexation, damage and possible ruin, and the interest of the courts in promoting the honest use of the judicial process * * *. The paramount value of the malicious prosecution action is thus the protection it affords to every individual.

Petitioner and other physicians have suffered very real and substantial damages as a result of having to defend groundless and bad-faith lawsuits. Their right to be free from such injury, which has been ignored by several states, including Illinois, is a matter of such magnitude as to deserve the concerned attention of this Court.[54]

[54] It should be noted that during 1975 and the next few years most States enacted legislation designed to alleviate some of the problems connected with the medical malpractice crisis. For a summary of these reforms, see National Conference of State Legislatures, *A Legislator's Guide to the Medical Malpractice Issue*, (1976); Comment, *Recent Medical Malpractice Legislation—A First Checklist*, 50 Tul. L. Rev. 655 (1976); *Redish, supra* note 29; *Blackwell, supra* note 16, at 21-22; *NAIC Study, supra* note 14, at 3; *Epstein, supra* note 6, at 128-49; Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Insurance Crisis*, 1975 Duke L.J. 1417. The constitutionality of many of these reforms is still being tested in the courts. *See, e.g.*, Hines v. Elkhart General Hospital, 465 F. Supp. 421 (N.D. Ind. 1979). Although many of the reforms do help physicians by limiting their liability directly or indirectly, or by making it more difficult for the plaintiff to recover, none of the reforms provides any assistance to the physician who has already been injured by a frivolous and bad faith lawsuit. Only a viable cause of action for malicious prosecution can serve that function.

Since the special injury requirement imposed by the court below effectively bars malicious prosecution suits, "[i]t is essential that those states still that adhere to the minority position, requiring proof of special injury in malicious prosecution actions, abrogate this restrictive rule." *Birnbaum, supra* note 4, at 1090. Only by abandoning the special damages requirement can the cause of action "work as an effective means to counter the increase in medical malpractice actions" [55] and serve to compensate the physician who suffers substantial harm from the filing of a purely frivolous suit.

B. The Legitimate Policy of Encouraging Free Access to the Courts Does Not Encompass Frivolous Claims Brought To Extort Nuisance Settlements or To Harass Physicians.

In order to avoid contributing to the very serious problems discussed in Section II, above, the courts can and must distinguish between frivolous, bad-faith claims, such as the original suit against the Petitioner here, and legitimate claims brought with a proper purpose. In purporting to rest its decision on a policy of encouraging free access to the courts, the court below ignored this vital distinction.

Legitimate claims brought in good faith by a litigant, whether or not ultimately successful, warrant the full protection of the courts. Dismissal of such claims, with costs of the action, are the only sanctions that the litigant should suffer. However, claims brought to harass a physician as part of a personal vendetta and claims brought to extort a nuisance settlement from the physi-

[55] *Adler, supra* note 7, at 57.

cian or his or her insurer deserve none of the protections afforded to legitimate claims brought in good faith. In the instant case, the jury found that Respondents willfully and wantonly and without probable cause filed a medical malpractice claim against Petitioner. The policy of encouraging free access to the courts does not require protection of such claims.

Instead, the courts have a duty to see that the backlogs created by groundless claims do not prevent a fair hearing of legitimate claims. This point was forcefully made by the United States Court of Appeals for the District of Columbia Circuit in its recent opinion in *Copeland* v. *Martinez*, No. 77-2059, 2060 (D.C. Cir., July 24, 1979), where it held that individuals who in bad faith bring baseless suits against the federal government alleging sex or race discrimination may be liable to the government for its attorneys' fees. The court said that "[l]itigation brought merely to harass is a wholly unredeemed burden and an affront to the judiciary" [56] and noted that the court has "no intention of sanctioning bad faith in judicial proceedings * * *." [57] If the courts fail to exercise this control over bad faith claims, the court noted:

> Sufficient abuse of the judicial process could overwhelm the courts and destroy the judicial system as an effective branch of government. This, and any discernible degree thereof, such as the bad faith litigation found here, the courts have a constitutional duty to prevent. [Slip op. at 22 n. 69.]

Accord, *Birnbaum*, *supra* note 4, at 1017 ("Some actions clearly are unjustifiably instituted and must be vigorously discouraged by both the bench and the bar," including

[56] Slip op. at 21.

[57] *Id.* at 22.

actions which are "brought solely to harass a physician as a result of a patient's spite, malice or ill will").[58]

Claims brought simply to extort settlements from physicians or their insurers are similarly unworthy of any protection by the courts. Mr. Chief Justice Burger, writing for this Court in its recent opinion in *Reiter* v. *Sonotone Corporation*, 47 U.S.L.W. 4672, 4676 (U.S., June 11, 1979), noted that "[d]istrict courts must be especially alert to identify frivolous claims brought to extort nuisance settlements * * *." In *Blue Chip Stamps* v. *Manor Drug Stores*, 421 U.S. 723 (1975), Mr. Justice Rehnquist, writing for the Court about the field of federal securities laws, said in words equally apropos to the medical malpractice situation that "a complaint which by objective standards may have very little chance of success at trial has a settlement value to the plaintiff out of any proportion to its prospect of success at trial so long as he may prevent the suit from being resolved against him by dismissal or summary judgment. The very pendency of the lawsuit may frustrate or delay normal business activity of the defendant which is totally unrelated to the lawsuit." 421 U.S. at 740. For all of the reasons described above, physicians are particularly vulnerable to suits brought to extort nuisance settlements. The courts have a duty to protect the physicians, and the court system itself, against these groundless and unjustifiably instituted claims.

Suits brought to extort a settlement are particularly pernicious because they not only are a result of the current crisis in the courts, but also are a cause of further

[58] *See also* Nemeroff v. Abelson, 469 F. Supp. 630 (S.D.N.Y. 1979) (where the court awarded defendants $50,000 in attorneys' fees and costs to be taxed against plaintiff *and* his counsel, following a stipulation of dismissal with prejudice of an action which was instituted "in bad faith, vexatiously, wantonly or for oppressive reasons"); Miracle Mile Associates v. City of Rochester, No. 78-592 (W.D.N.Y. May 18, 1979).

exacerbation of the problem. As the volume of cases increases due to frivolous claims, the delays and backlogs in the courts increase, and it becomes more costly to litigate a claim. As the time and expense of litigation thus increases, insurers feel more pressure to settle claims. This, in turn, encourages people to bring more strike suits, and a vicious circle is created.

The Illinois Appellate Court concluded in its opinion in the instant case that the state's "overriding public policy" of preserving "free and unfettered access to the courts" predominated over the need to protect the courts from "misuse and the physician from the resulting harm." Pet. at 14a. However, the concern for not wanting to discourage legitimate claims is not a reason to afford protection to totally unjustified actions. In *Copeland* v. *Martinez*, *supra*, the District of Columbia Circuit found unpersuasive the plaintiff's similar arguments concerning the "alleged chill on potentially valid litigation." Slip op. at 19. The court said the alleged chill would not occur unless persons with meritorious claims "believed that courts were likely so to mischaracterize those suits as to find them not only without merit, but wholly vexatious as well." *Id.*[59]

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[59] In *Herbert* v. *Lando*, 47 U.S.L.W. 4401 (U.S., April 18, 1979), the respondents made, and lost, an argument directly analogous to the one asserted by Respondents here. The media in that case contended that allowing plaintiffs in libel actions to inquire into the editorial process and the states of mind of those involved in that process would have a chilling effect on the publication of news. This Court responded that

> if the claimed inhibition flows from the fear of damages liability for publishing knowing or reckless falsehoods, those effects are precisely what *New York Times* [v. *Sullivan*, 376 U.S. 254 (1964)] and other cases have held to be consistent with the First Amendment. Spreading false information in and of itself carries no First Amendment credentials. * * * Those who publish defamatory falsehoods with the requisite culpability * * * are subject to liability, the aim being not only to compensate for injury but also to deter publication of unprotected material threatening injury to individual reputation. * * * If such [direct] proof results in liability for damages which in turn discourages the publication of erroneous information known to be false or probably false, this is no more than what our cases contemplate * * *. [47 U.S.L.W. at 4405-06.]

And so here, if recoveries such as that awarded by the jury to Petitioner have the effect of discouraging unfounded, frivolous or malicious lawsuits, that result is not only acceptable but laudatory. The plaintiff with a meritorious claim will no more be inhibited from pursuing it in the face of such a recovery than would the publisher in *Herbert* who was confident that his news was true and accurate.

Furthermore, it should be emphasized that the defendant physician, who is severely injured by a groundless lawsuit, like Petitioner here, deserves the protection of the courts through the preservation of a viable remedy. As one commentator has written, "Fearing a denial of access to the courts, the judiciary has neglected its duty to protect the unjustly accused defendant." *Kisner*, *supra* note 2, at 685. The bad-faith litigant does not have any interests that are worthy of the courts' protection, and clearly none that overrides those of the unjustly accused physician.

The courts and juries are fully capable of distinguishing between borderline suits brought in good faith and frivolous claims brought to extort a settlement or to harass physicians. The courts should not place these two kinds of plaintiffs on the same footing. *See Teesdale* v. *Liebschwager*, 42 S.D. 323, 325, 174 N.W. 620 (1919), *cited in* F. Harper and F. James, 1 *The Law of Torts* § 4.8 at 327-28 (1956):

> To hold that statutes, allowing a successful defendant costs, furnish the only indemnity for such defendant, and this whether or [not] there has been a malicious perversion of legal remedies, places the plaintiff who lawfully uses, and the plaintiff who maliciously perverts the right to sue, upon precisely the same footing with respect to the question of

> liability for their respective acts. To thus place one who maliciously perverts the remedies which the law has provided for the good-faith litigant upon the same footing as such good-faith litigant would not only be monstrous and unjust, but fraught with great public evil, in that it would encourage the unscrupulous to use our courts as instruments with which to maliciously injure their fellow men.

Courts should protect the rights of persons with legitimate grievances to bring a lawsuit. At the same time, physicians should not be denied a counter-remedy against those who bring totally unjustified actions. *See Stimson*, *supra* note 16, at 622:

> Patients who bring suit which does not meet the necessary burden of proof but has some basis, should be subjected only to the failure of the cause of action. Those patients, however, who recklessly bring a malpractice action, either without probable cause or with some ulterior motive, should not be afforded the protection given by the judicial process to legitimate actions and should be held liable in a countersuit brought by an injured physician.

The courts are capable of distinguishing between frivolous, bad-faith claims and legitimate, even if non-meritorious, claims which deserve judicial protection. By refusing to consider such a distinction in the instant case, the court below denied Petitioner and all other physicians damaged by frivolous claims the only effective remedy against this abuse. The lower court also failed to consider the other serious impacts on the nation's health care system and on the courts resulting from the increased filing of groundless claims. Thus, the losers as a result of this decision are not only physicians and the court system, but the public whom physicians and the judiciary attempt so vigorously and effectively to serve.

CONCLUSION

For the foregoing reasons, as well as those stated in the Petition for a Writ of Certiorari previously filed in this case, this Court should grant a Writ of Certiorari and reverse the decision below.

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